CANNON BUILDING
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

# Verification of Post Graduate Medical Education

| Institution:<br><br>Address:<br><br>City/State/Zip: | Affiliated University: |
|---|---|

**This section is to be completed by the applicant.**

Last Name:_____ First Name:_____

SSN:_____ DOB: _____

Name if Different from Above:_____

**Program Participation:**

**Please report incomplete post graduate training (PGT) years separately from those that were successfully completed.**

**If the postgraduate year is currently in the process, report the expected completion date in the "To" field.**

**Report Internships, Residencies and Fellowships separately.**

**Use one section per department. If the department is rotating or traditional, please provide a schedule of rotations.**

PGY Year: _____

___ Internship
___ Residency
___ Fellowship
___ Research
___ Other

Department: _____

From: _____/_____/_____ (MM/DD/YY) To: _____/_____/_____ (MM/DD/YY)

Successfully Completed?: Yes_____ No _____ _____ In Progress

Accredited By: ___ACGME ___AOA ___Not Accredited ___Other _____

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PGY Year: _____

___ Internship
___ Residency
___ Fellowship
___ Research
___ Other

Department: _____

From: _____/_____/_____ (MM/DD/YY) To: _____/_____/_____ (MM/DD/YY)

Successfully Completed?: Yes _____ No _____ _____ In Progress

Accredited By: ___ACGME ___AOA ___Not Accredited ___Other _____

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PGY Year: _____

___ Internship
___ Residency
___ Fellowship
___ Research
___ Other

Department: _____

From: _____/_____/_____ (MM/DD/YY) To: _____/_____/_____ (MM/DD/YY)

Successfully Completed?: Yes_____ No _____ _____ In Progress

Accredited By: ___ACGME ___AOA ___Not Accredited ___Other _____

Unusual Circumstances

**PLEASE EXPLAIN ANY "YES" RESPONSE ON A SEPARATE SHEET OF PAPER.**

**COMPLETION OF THIS SECTION IS MANDATORY**

Did this individual ever take a leave of absence or break from training? Yes No

Was this individual ever placed on probation? Yes No

Was this individual ever disciplined or placed under investigation? Yes No

Did the instructors file any negative reports on this individual? Yes No

Were any limitations or special restrictions placed on this individual because of questions of academic incompetence, disciplinary problems or any other reason? Yes No

**CERTIFICATION**

*****AFFIX INSTITUTIONAL OR NOTARIAL SEAL HERE**

**Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. This section MUST be signed by the Program Director (M.D. / D.O. only).**

**Name:**_____ **Signature:**_____

**Title:**_____ **Date of Signature:** _____

**Tel:** _____ **Fax:** _____ **E-mail:** _____

*****RETURN COMPLETED FORM WITH SEAL AFFIXED TO THE BOARD ADDRESS ABOVE. THANK YOU. DO NOT FAX.**